IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients,

and

SACHEEN CARR-ELLIS, M.D., M.P.H., on behalf of herself and her patients,

Plaintiffs,

v.

THOMAS DOBBS, M.D., in his official capacity as State Health Officer of the Mississippi Department of Health, et al.

Defendants.

Case No. 3:18-cv-171-CWR-FKB

PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

Pursuant to Fed. R. Civ. P. 65, Plaintiffs, by and through their undersigned counsel, respectfully move this Court for a preliminary injunction enjoining Defendants from enforcing Senate Bill 2116 ("S.B. 2116"), which bans abortion after approximately 6 weeks. S.B. 2116 is scheduled to take effect July 1, 2019 and will ban nearly all pre-viability abortions in the state of Mississippi.

This Motion is supported by the Memorandum of Law in Support of Plaintiffs' Motion for a Preliminary Injunction, a copy of S.B. 2116 (attached as Exhibit A), and the Declaration of Sacheen Carr-Ellis, M.D., M.P.H. (attached as Exhibit B).

As set out in the accompanying memorandum of law, Plaintiffs have demonstrated a substantial threat of irreparable injury, for which there is no adequate remedy at law, if S.B. 2116

is not enjoined prior to July 1, 2019. Plaintiffs' application is supported by specific facts that clearly show their entitlement to a preliminary injunction, which will prevent injury and maintain the status quo pending final resolution of the significant constitutional claims at issue. Plaintiffs respectfully request that the Court grant Plaintiffs' Motion for a Preliminary Injunction.

Respectfully submitted this 28th day of March, 2019.

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CERTIFICATE OF SERVICE

I hereby certify that on March 28, 2019, I electronically filed the foregoing Plaintiffs' Motion for a Preliminary Injunction with the Clerk of the Court by using the Court's CM/ECF system, which will send a notice of electronic filing to all counsel of record.

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Exhibit A

MISSISSIPPI LEGISLATURE REGULAR SESSION 2019

By: Senator(s) Hill, Caughman, Fillingane, Watson, Blackwell, McDaniel, Parker, Seymour, Jackson (15th), Younger, McMahan, Whaley, Massey, Doty, Parks, Branning

To: Public Health and Welfare

SENATE BILL NO. 2116
(As Sent to Governor)

AN ACT TO CREATE NEW SECTION 41-41-34.1, MISSISSIPPI CODE OF 1972, TO PROHIBIT AN ABORTION OF AN UNBORN HUMAN INDIVIDUAL WITH A DETECTABLE FETAL HEARTBEAT EXCEPT TO PREVENT THE DEATH OF THE PREGNANT WOMAN OR TO PREVENT A SERIOUS RISK OF THE SUBSTANTIAL AND IRREVERSIBLE IMPAIRMENT OF A MAJOR BODILY FUNCTION OF THE WOMAN; TO AMEND SECTION 73-25-29, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT A PHYSICIAN PERFORMING AN ABORTION ON A PREGNANT WOMAN AFTER DETERMINING THAT THE UNBORN HUMAN INDIVIDUAL HAS A DETECTABLE FETAL HEARTBEAT IS SUBJECT TO LICENSE REVOCATION OR DISCIPLINARY ACTION; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following provision shall be codified as Section 41-41-34.1, Mississippi Code of 1972:

41-41-34.1. (1) As used in this section:

(a) "Fetal heartbeat" means cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac.

(b) "Physician" means a person licensed to practice medicine under Section 73-25-1 et seq.

(c) "Unborn human individual" means an individual organism of the species homo sapiens from fertilization until live birth.

(2) (a) Except as provided in paragraph (b) or (c) of this subsection (2), no person shall knowingly perform an abortion on a pregnant woman with the specific intent of causing or abetting the termination of the life of the unborn human individual that the pregnant woman is carrying and whose fetal heartbeat has been detected. Any person who acts based on the exception in paragraph (b) or (c) of this subsection (2) shall so note in the pregnant woman's medical records and shall specify in the pregnant woman's medical records which of the exceptions the person invoked.

(b) (i) A person is not in violation of paragraph (a) of this subsection (2) if that person performs a medical procedure designed to or intended, in that person's reasonable medical judgment, to prevent the death of a pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(ii) Any person who performs a medical procedure as described in paragraph (b)(i) of this subsection (2) shall declare in writing, under penalty of perjury, that the medical procedure was necessary, to the best of that person's reasonable medical judgment, to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman. That person shall also provide in that written document, under penalty of perjury, the medical condition of that pregnant woman that the medical procedure performed as described in paragraph (b)(i) of

this subsection (2) will assertedly address, and the medical rationale for the conclusion that the medical procedure was necessary to prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

(iii) The person who performs a medical procedure as described in paragraph (b)(i) of this subsection (2) shall place the written documentation required under paragraph (b)(ii) of this subsection (2) in the pregnant woman's medical records, and shall maintain a copy of the written documentation in the person's own records for at least seven (7) years.

(c) A person is not in violation of paragraph (a) of this subsection (2) if that person has performed an examination for the presence of a fetal heartbeat in the unborn human individual using standard medical practice and that examination does not reveal a fetal heartbeat or the person has been informed by a physician who has performed the examination for a fetal heartbeat that the examination did not reveal a fetal heartbeat.

(d) This subsection (2) does not repeal any other provision of the Mississippi Code that restricts or regulates the performance of an abortion by a particular method or during a particular stage of a pregnancy.

(e) Any person who violates this subsection (2) is guilty of performing an abortion after the detection of a fetal heartbeat, a violation punishable as provided in Section 41-41-39.

SECTION 2. Section 73-25-29, Mississippi Code of 1972, is amended as follows:

73-25-29. The grounds for the nonissuance, suspension, revocation or restriction of a license or the denial of reinstatement or renewal of a license are:

(1) Habitual personal use of narcotic drugs, or any other drug having addiction-forming or addiction-sustaining liability.

(2) Habitual use of intoxicating liquors, or any beverage, to an extent which affects professional competency.

(3) Administering, dispensing or prescribing any narcotic drug, or any other drug having addiction-forming or addiction-sustaining liability otherwise than in the course of legitimate professional practice.

(4) Conviction of violation of any federal or state law regulating the possession, distribution or use of any narcotic drug or any drug considered a controlled substance under state or federal law, a certified copy of the conviction order or judgment rendered by the trial court being prima facie evidence thereof, notwithstanding the pendency of any appeal.

(5) Procuring, or attempting to procure, or aiding in, an abortion that is not medically indicated.

(6) Conviction of a felony or misdemeanor involving moral turpitude, a certified copy of the conviction order or

judgment rendered by the trial court being prima facie evidence thereof, notwithstanding the pendency of any appeal.

(7) Obtaining or attempting to obtain a license by fraud or deception.

(8) Unprofessional conduct, which includes, but is not limited to:

(a) Practicing medicine under a false or assumed name or impersonating another practitioner, living or dead.

(b) Knowingly performing any act which in any way assists an unlicensed person to practice medicine.

(c) Making or willfully causing to be made any flamboyant claims concerning the licensee's professional excellence.

(d) Being guilty of any dishonorable or unethical conduct likely to deceive, defraud or harm the public.

(e) Obtaining a fee as personal compensation or gain from a person on fraudulent representation of a disease or injury condition generally considered incurable by competent medical authority in the light of current scientific knowledge and practice can be cured or offering, undertaking, attempting or agreeing to cure or treat the same by a secret method, which he refuses to divulge to the board upon request.

(f) Use of any false, fraudulent or forged statement or document, or the use of any fraudulent, deceitful, dishonest or immoral practice in connection with any of the

licensing requirements, including the signing in his professional capacity any certificate that is known to be false at the time he makes or signs such certificate.

(g) Failing to identify a physician's school of practice in all professional uses of his name by use of his earned degree or a description of his school of practice.

(9) The refusal of a licensing authority of another state or jurisdiction to issue or renew a license, permit or certificate to practice medicine in that jurisdiction or the revocation, suspension or other restriction imposed on a license, permit or certificate issued by such licensing authority which prevents or restricts practice in that jurisdiction, a certified copy of the disciplinary order or action taken by the other state or jurisdiction being prima facie evidence thereof, notwithstanding the pendency of any appeal.

(10) Surrender of a license or authorization to practice medicine in another state or jurisdiction or surrender of membership on any medical staff or in any medical or professional association or society while under disciplinary investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this section.

(11) Final sanctions imposed by the United States Department of Health and Human Services, Office of Inspector General or any successor federal agency or office, based upon a

finding of incompetency, gross misconduct or failure to meet professionally recognized standards of health care; a certified copy of the notice of final sanction being prima facie evidence thereof. As used in this paragraph, the term "final sanction" means the written notice to a physician from the United States Department of Health and Human Services, Officer of Inspector General or any successor federal agency or office, which implements the exclusion.

(12) Failure to furnish the board, its investigators or representatives information legally requested by the board.

(13) Violation of any provision(s) of the Medical Practice Act or the rules and regulations of the board or of any order, stipulation or agreement with the board.

(14) Violation(s) of the provisions of Sections 41-121-1 through 41-121-9 relating to deceptive advertisement by health care practitioners.

(15) Performing or inducing an abortion on a woman in violation of any provision of Sections 41-41-131 through 41-41-145.

(16) Performing an abortion on a pregnant woman after determining that the unborn human individual that the pregnant woman is carrying has a detectable fetal heartbeat as provided in Section 41-41-34.1.

In addition to the grounds specified above, the board shall be authorized to suspend the license of any licensee for being out

of compliance with an order for support, as defined in Section 93-11-153. The procedure for suspension of a license for being out of compliance with an order for support, and the procedure for the reissuance or reinstatement of a license suspended for that purpose, and the payment of any fees for the reissuance or reinstatement of a license suspended for that purpose, shall be governed by Section 93-11-157 or 93-11-163, as the case may be. If there is any conflict between any provision of Section 93-11-157 or 93-11-163 and any provision of this chapter, the provisions of Section 93-11-157 or 93-11-163, as the case may be, shall control.

SECTION 3. This act shall take effect and be in force from and after July 1, 2019.

Exhibit B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients,

and

SACHEEN CARR-ELLIS, M.D., M.P.H., on behalf of herself and her patients,

Plaintiffs,

v.

THOMAS DOBBS, M.D., M.P.H., in his official capacity as State Health Officer of the Mississippi Department of Health, et al.

Defendants.

Case No. 3:18-cv-171-CWR-FKB

DECLARATION OF SACHEEN CARR-ELLIS, M.D., M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

Sacheen Carr-Ellis, M.D., M.P.H., declares and states as follows:

1. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction. I am a board-certified obstetrician/gynecologist (ob/gyn) licensed to practice medicine in Mississippi. I received my M.D. from Albany Medical College in 1999. After my residency in obstetrics and gynecology, I completed a fellowship in family planning at Boston University Medical Center in Boston, Massachusetts, which included training in abortion. I also hold a master's degree in public health from Boston University. My curriculum vitae, which sets forth my expertise and credentials in greater detail, is attached as Exhibit 1.

2. The opinions in this declaration are my expert opinions, based on my education, clinical experience, attendance at conferences, and familiarity with the relevant medical

literature.

Background

3. I have been providing abortion services since 1999. Over the course of my medical career, I have regularly provided both first trimester and second trimester abortions.

4. I joined Jackson Women's Health Organization ("the Clinic") in 2014 and became Medical Director in April 2015. To the best of my knowledge, the Clinic is the only regular provider of legal abortion in Mississippi.

5. As Medical Director, I oversee the Clinic's medical practice, including reviewing and establishing medical policies and protocols. I am also one of the Clinic's clinicians and provide contraceptive and abortion services to the Clinic's patients.

6. The Clinic is open six days per week, but abortion care is typically offered on only two to three days per week. Over the last several years, the Clinic has provided more than 2,000 abortions per year.

7. Abortion care is available at the Clinic from about 5 weeks LMP through 16 weeks, 0 days LMP.[1] At the Clinic, I provide medication abortion up to 10 weeks, 0 days LMP, consistent with current evidence-based medical practice, and aspiration (surgical) abortions up to 16 weeks, 0 days LMP.

8. Under Mississippi law, a patient must make two in-person visits to the Clinic in order to obtain an abortion, separated by at least twenty-four hours. An ultrasound is performed for each patient at their first visit. An ultrasound is performed for a variety of reasons, including dating the pregnancy and determining whether the pregnancy is located in the patient's uterus.

[1] Pregnancy is commonly measured by the number of days that have passed since the first day of a woman's last menstrual period ("LMP"), also referred to as "gestational age." LMP does not always correlate with the actual number of days since a given woman's last period, including because women may ovulate without having a menstrual period two weeks before. LMP may be better understood as roughly two weeks before fertilization.

Ultrasound is also used to detect embryonic or fetal cardiac activity.

9. The earlier in pregnancy the patient is, the more likely a clinician is to use vaginal ultrasound, rather than abdominal ultrasound, to determine the location and gestational age of the embryo.[2] A vaginal ultrasound is inserted directly into the vagina, which creates a clearer image than abdominal ultrasound, to confirm whether the pregnancy is in the uterus and whether cardiac activity is present.

10. The Clinic does not typically perform abortions before 5 weeks, 0 days LMP because, due to the embryo's very small size, it may not be possible to confirm the location of the pregnancy, including using vaginal ultrasound. The standard of care is to confirm a pregnancy is in the uterus before an abortion.

11. Using vaginal ultrasound, cardiac activity is generally detectable at approximately 6 weeks, 0 days LMP. At this point in pregnancy, the embryo is tiny, and embryonic cardiac activity is an electrical impulse that can be seen, not heard, on ultrasound. On the ultrasound, the yolk sac looks like a ring, and cardiac activity is a flicker on the edge of the yolk sac.

S.B. 2116 Bans Abortion Prior to Viability

12. I have reviewed Mississippi S.B. 2116, which bans abortion once a fetal heartbeat has been detected. As stated above, this generally happens very early in pregnancy, at approximately 6 weeks, 0 days LMP. As a practical matter, S.B. 2116 is a near total ban on abortion. Indeed, it bans abortion before many women make their first visit to the Clinic.

13. Many women have no reason to suspect that they may be pregnant before they miss a period. To put S.B. 2116 in perspective, for a woman with an average menstrual cycle (*e.g.*, a period every 28 days), 6 weeks, 0 days LMP is just two weeks after a missed period.

[2] Embryo is the medical term used for a developing fetus until the eleventh week of gestation.

14. However, many women may have none of the physical indicators of pregnancy, such as a missed menstrual period, at 6 weeks LMP. Many women do not menstruate at regular intervals or go long stretches without experiencing a menstrual period, and therefore may not realize they may be pregnant as early as 6 weeks LMP. Indeed, it is normal for women to have an ovulatory cycle at some point in their lives that is not within two weeks of their last menstrual period. Additionally, women may experience bleeding—including bleeding in early pregnancy—that can be mistaken for a period.

15. Further, women who have certain medical conditions, who are breastfeeding, or who use hormonal contraceptives may not experience a missed period at 6 weeks LMP. Breastfeeding, for example, can suppress menstruation for weeks or months, and even after a woman's period returns, it may continue to be irregular. It is not uncommon for a breastfeeding woman to have a shorter or longer period than normal, to skip a period, or to have a period return and then go months before the next one. Additionally, women using hormonal contraception can become pregnant, but may not have regular periods or experience a period at all. Women who are obese may also have irregular periods, or intra-menstrual bleeding (bleeding that is not a menstrual period).

16. For all of these reasons, a woman may be 6 weeks pregnant but not realize she has missed a period, much less consider a missed period unusual or a signal that she may be pregnant.

17. If the ban takes effect, the Clinic will have to stop providing most abortion care, because neither I nor the Clinic's other clinicians can risk the criminal, civil, and other penalties that the ban imposes.

18. Nearly all of the Clinic's patients obtain abortion care at or after 6 weeks, 0 days

LMP. If the ban takes effect, most women seeking abortion in Mississippi will either be forced to carry their pregnancy to term against their will or to leave the state to obtain care.

19. As a ban on abortion at approximately 6 weeks LMP, S.B. 2116 prohibits abortions many months before the time in pregnancy when a fetus may be viable, by which I mean that in the judgment of the attending clinician on the particular facts of the case before him or her, there is a reasonable likelihood of the fetus's sustained survival outside the womb, with or without artificial support.

20. Viability is medically impossible at 6 weeks LMP. Based on my education, training, and decades as a practicing ob-gyn, it is my medical opinion that viability does not occur in a normally developing pregnancy until 23 weeks LMP at the earliest. Some fetuses are never viable.

21. A woman who is pregnant should have the ability to make the decision that is best for her about the course of her pregnancy, based on her own values and goals for her life. The ban removes that decision from the woman and places it, instead, in the hands of the State.

22. Additionally, access to safe and legal abortion benefits the health and wellbeing of patients and their families. The availability of abortion enables patients not to forego educational and economic opportunities due to unplanned childbirth, to provide care to existing family members, to avoid raising children with an absent or unwilling partner, and to prevent medical harms that arise from carrying risky pregnancies to term. Over the years, my patients have raised all of these concerns as reasons why they have made the decision to end a pregnancy.

23. The ban presents me with an impossible choice: to face potential criminal and civil penalties and loss of my Mississippi medical license for continuing to safely provide abortion care or to stop providing my patients the care they seek and deserve.

I declare under penalty of perjury that the foregoing is true and correct.

Sacheen Carr-Ellis, M.D., M.P.H.

Executed March 26, 2019 in Jackson, Mississppi

Exhibit 1

Curriculum Vitae
Sacheen Nathan, MD, MPH

[redacted]

ACADEMIC TRAINING:

5/1995 BS	Union College, Schenectady, NY; Biology and Chemistry
5/1999 MD	Albany Medical College, Albany, NY
12/2005 MPH	Boston University, Boston, MPH; Biostatistics

POSTDOCTORAL TRAINING:

7/1999-6/2003	Residency in Obstetrics and Gynecology, New York Medical College, New York, NY
7/2003-6/2005	Fellowship in Family Planning and Public Health, Boston Medical Center, Boston, MA

ACADEMIC APPOINTMENTS:

2/2010-4/2014	Assistant Professor of Obstetrics and Gynecology, Boston University School of Medicine, Boston, MA
7/2005-2/2010	Instructor of Obstetrics and Gynecology, Boston University School of Medicine, Boston, MA

HOSPITAL APPOINTMENTS:

7/2005-4/2014	Attending Gynecologist, Boston Medical Center, Boston, MA

HOSPITAL AFFILIATION:

4/2014-Present	Refer and follow privilege, Boston Medical Center, Boston, MA

OTHER PROFESSIONAL AND VOLUNTEER EXPERIENCE:

6/1997-8/1997	Internship, New York State Department of Health, Bureau of Women's Health, New York, NY
11/2003-2008	Quincy Teen Mothers, Quincy High School, Quincy, MA
9/2004-Present	Healing Our Community Collaborative, Asylum Network, Boston, MA
7/2005-Present	Clinician, Planned Parenthood League of Massachusetts, Boston MA
2/2005	Clinical Workshops and Health Clinics, Marie Stopes Kenya, Nairobi Kenya
4/2005	Clinician Training in abortion and miscarriage management. Mexico City, Mexico
5/2013-12/2015	Clinician, Four Women Health Services, Attleboro MA
7/2014-4/2017	Clinician, Planned Parenthood South East, Atlanta GA
9/2014-Present	Clinician, Whole Women's Health, Baltimore MD
9/2015-Present	Clinician, Reproductive Health Services, Montgomery AL
1/2016-Present	Clinician, West Alabama Women's Center, Tuscaloosa AL
10/2014-Present	Medical Director, Jackson Women's Health, Jackson MS

HONORS:

1999	Dr. George C. Carter Award for growth and development of the Minority Affairs department, Albany Medical College, Albany, NY
2003	Resident Humanism Award, New York Medical College
2003	3rd Prize, Resident Research Award, New York Medical College
2003	Wyeth Pharmaceuticals New Leaders Award
2004	Wyeth Pharmaceuticals New Leaders Award
2008	CREOG Faculty Award for Excellence in Resident Teaching, Department of Obstetrics and Gynecology, Boston University School of Medicine, Boston, MA

LICENSES AND CERTIFICATION:

5/2003	Massachusetts License #216743

4/2014	New York License # 274959-1
4/2014	Georgia License #72378
5/2014	Maryland License #D77891
6/2014	Alabama License #MD.33448
9/2014	Mississippi License #23483
1/2007	American Board of Obstetrics and Gynecology, Diplomate #9007221

DEPARTMENTAL AND UNIVERSITY COMMITTEES:

11/2005-4/2014	Member, Ethics Committee, Boston Medical Center, Boston, MA
3/2013-4/2014	Board Member, Boston University OB/GYN Foundation, Boston, MA

TEACHING EXPERIENCE AND RESPONSIBILITIES:

7/2005-4/2014	Core Faculty in Family Planning Fellowship, Boston Medical Center, Boston, MA
7/2005-4/2014	Resident Teaching in Family Planning and General Gynecology, Boston Medical Center, Boston, MA
7/2005-4/2014	Medical Student Teaching in Family Planning and General Gynecology, Boston Medical Center, Boston, MA

MAJOR ADMINISTRATIVE RESPONSIBILITIES:

7/2005-4/2014	Director for 1st and 2nd year Medical Students in Medical Student for Choice-Sponsored Summer Rotation in Family Planning, Boston Medical Center, Boston, MA
7/2007-4/2014	Clinical Director of Family Planning, Boston Medical Center, Boston, MA
7/2008-4/2014	Director, 4th Year Boston University Medical Student Elective in Family Planning, Boston Medical Center, Boston, MA
7/2009-6/2013	Faculty Advisor for Ob/Gyn Residency Class of 2013
7/2008-7/2010	Faculty Advisor for OB/Gyn Pre-operative conference, Boston University Obstetrics and Gynecology. Boston Medical Center, Boston, MA
7/2009-4/2014	Director, Ryan Program in Resident Teaching in Family Planning, Boston Medical Center, Boston, MA
7/2009-4/2014	Co Director, Fellowship in Family Planning, Boston Medical Center, Boston, MA
4/2015-present	Medical Director Jackson Women's Health Organization, Jackson MS

MAJOR ADMINISTRATIVE PROJECTS:

7/2005	Development of the outpatient sterilization program. Boston University Obstetrics and Gynecology. Boston Medical Center
7/2006	Planning Committee for Gynecologic Procedure Unit. Boston University Obstetrics and Gynecology. Boston Medical Center, Boston, MA
7/2009-4/2014	Scheduling for Family Planning Clinics. Boston University Obstetrics and Gynecology. Boston Medical Center, Boston, MA
7/2009-4/2014	Family Planning Billing Project, Boston University Obstetrics and Gynecology, Boston Medical Center, Boston, MA
7/2011-4/2014	Family Planning Protocol Updates, Boston University Obstetrics and Gynecology, Boston Medical Center, Boston, MA
5/2013-5/2014	Family Planning Project with homeless women in Boston, MHSA Scattered Sites, Dorchester, MA

OTHER PROFESSIONAL ACTIVITIES:

PROFESSIONAL SOCIETIES: MEMBERSHIPS, OFFICES, AND COMMITTEE ASSIGNMENTS

1999-2008	Junior Fellow, American Congress of Obstetricians and Gynecologists
2003-Present	Association of Reproductive Health Providers
2006-Present	Massachusetts Medical Society
2009-Present	Fellow, American Congress of Obstetricians and Gynecologists
2013-Present	Affiliate Fellow, Society of Family Planning

MAJOR COMMITTEE ASSIGNMENTS:

Private/Foundation

9/2005-6/2009	Executive Board Member, Abortion Access Project, Cambridge, MA
1/2011-8/2014	Board Member, Black Women's Health Imperative, Washington, DC
2/2014-present	Board Member, Population Connection, Washington DC

Invited Lectures and Presentations:

1999	Female Sexual Function. Grand Rounds. Metropolitan Hospital, New York, NY.
2000	Adolescent Pregnancy and Abstinence Only Education. Grand Rounds. Metropolitan Hospital, New York, NY.
2002	Unwanted Pregnancy and Title X of the Public Health Service Act. Grand Rounds. Westchester Medical Center, Valhalla, NY.
2003	Implants and Injectables. Avances Recientes en Anticoncepcion. Bogotá, Colombia.
2003	Barrier Methods. Avances Recientes en Anticoncepcion. Bogotá, Colombia.
2003	Withdrawal, A good alternative? Avances Recientes en Anticoncepcion. Bogotá, Colombia.
2003	Medical Abortion. 7^{h} Annual New England Regional Conference Health Profession Students for Choice. Boston, MA.
2004	Mifepristone Training for Primary Care Practitioners. Boston University Department of Family Medicine and the Abortion Access Project. Boston, MA.
2004	Why Emergency Contraception is Important to Your Practice: Key Facts for Providers. The New Hampshire Reproductive Health Association and Dartmouth-Hitchcock Medical Center. Laconia, NH.
2004	Intrauterine Contraception. East Boston Neighborhood Health Center. Boston MA.
2008	Long Acting Reversible Contraception. Family Planning Fellowship Meeting. New Orleans, LA.
2008	Overcoming Cultural Barriers in Contraceptive Care. Grand Rounds. Boston Medical Center, Boston, MA.
2009	Update on Long Acting Reversible Contraception. Grand Rounds. Tufts Medical Center, Boston, MA.
2010	Medication Abortion: Clinical Evidence and Managing Complications. Webinar. Ryan Training Program
2010	Clinical Conundrums: Contraception and the complicated Patient. Grand Rounds. Washington Hospital Center, Washington DC.
2010	Values Clarification Workshop. Washington Hospital Center, Washington DC
2010	The Modern IUD. Grand Rounds. Beverly Hospital, Beverly Massachusetts

Bibliography:

TEXTBOOK CHAPTERS:

1. Stubblefield P, Carr-Ellis S, Kapp N. Family Planning. In *Berek & Novak's Gynecology 14th ed.* Lippincott Williams and Wilkins, Philadelphia, PA, 2007.

ORIGINAL, PEER REVIEWED ARTICLES:

1. Carr-Ellis S, Kapp N, Vragovic O, Borgatta L Randomized trial of buccal vs. vaginal misoprostol for induction of second trimester abortion. Contraception 2010;81(5):441-445
2. Stubblefield P, Carr-Ellis S, Borgatta L. Methods for induced abortion. Obstet Gynecol. 2004;104(1):174-185.
3. Kapp N, Borgatta L, Carr-Ellis S, Stubblefield P. Simultaneous very low dose mifepristone and vaginal misoprostol for medical abortion. Contraception 2006;73(5):525-7.
4. Green J, Borgatta L, Sia M, Kapp N, Saia K, Carr-Ellis S, Vragovic O. Intervention rates for placental removal following induction abortion with misoprostol. Contraception 2007;76(4):310-3.